Confidential Dental and Medical History

Patient's Name _____ **Age** _____ **Date of Birth** _____

Address _____ **City, State,Zip** _____

Home Phone _____ **Cell** _____

Work Phone _____ **Email** _____

Best Contact: ☐ **Email** ☐ **Cell** ☐ **Text** ☐ **Home** **best Time to Reach You:**

SS# _____ **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

Employer _____ **Employer Address** _____

Spouse's Name _____ **Spouse's Phone: (Work)** _____ **(Cell)** _____

Emergency Contact _____ **Relation** _____ **Emergency Phone** _____

Do you have dental insurance? ☐ **YES** ☐ **NO** **If YES, Insurance Carrier's Name**

Group # _____ **Phone** _____ **Subscriber's Name** _____

Relation to patient _____ **Subscriber's SS#** _____ **Subscriber's Date of Birth** _____

Employer/Co.Name _____ **Phone** _____

Employer/Co.Address,City,State,Zip _____

Insurance Carrier Address,City,State,Zip _____

HOW DID YOU HEAR ABOUT US? _____

Would you like to receive appointment reminders via text message? ☐ **YES** ☐ **NO**

Would you like to become friends with _____ **on Social Media to receive special offers?** ☐ **YES** ☐ **NO**

OFFICE POLICY REGARDING INSURANCE:
Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a cortesy, we will file your claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to _____ at the time of my visit. Failure to provide our office with all information necessary to file your insurance claim will require full payment at the time of service. Any portion of treatment that insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consect to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full after (45) days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

_____ _____

TYPE NAME **DATE**